



Florida Department of Health Investigation Form:
Middle East Respiratory Syndrome Coronavirus (MERS) Patient Under Investigation (PUI)
(Revised 05/20/2014; FDOH V 1.0)

For patients who meet the definition of a MERS PUI, complete this form, scan and attach to a corresponding Merlin record. Please create a case in Merlin for each PUI identified and attach this form. If you have questions afterhours, contact FDOH Bureau of Epidemiology at 850-245-4401.

Merlin ID:	Date CHD notified: MM/DD/YY	County:
Interviewer's name:		Phone:
Reporter's name:		
Physician's name:	Phone:	Pager:
Facility (hospital) name:	Phone:	IP's name:
Facility Address:		
Patient Information		
Patient name:	Phone(home):	Phone(cell):
Residency: <input type="checkbox"/> US resident <input type="checkbox"/> Non US resident	Country:	Email:
Address: _____		
City:	State:	Zip code:
Interviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Investigated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Date Interviewed: MM/DD/YY	Date Investigated: MM/DD/YY	
1. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female 2. Age: <input type="checkbox"/> year <input type="checkbox"/> month 3. DOB: MM/DD/YY		
4. Race: <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> Asian/Pacific Is <input type="checkbox"/> Am Indian/AK native <input type="checkbox"/> Other <input type="checkbox"/> Unk 5. Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hisp <input type="checkbox"/> Unk		
6. Usual occupation: 7. Industry:		
Clinical Presentation		
8. History of fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown specify highest _____ °C / °F		
9. Respiratory illness (circle all that apply: may include pneumonia, acute respiratory distress syndrome [ARDS], or other serious respiratory condition)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
10. Is/Was the patient: a. Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date: MM/YY/DD b. Admitted to ICU? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date: MM/YY/DD c. Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date: MM/YY/DD d. Visited ED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date: MM/YY/DD		11. Has patient received a diagnosis of: Pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ARDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Renal failure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Other? Specify: _____
12. Date of illness (fever) onset: MM/DD/YY		
13. Symptoms (Check all that apply): <input type="checkbox"/> Fever MM/DD/YY <input type="checkbox"/> Dry cough MM/DD/YY <input type="checkbox"/> Productive cough MM/DD/YY <input type="checkbox"/> Chills MM/DD/YY <input type="checkbox"/> Sore throat MM/DD/YY <input type="checkbox"/> Headache MM/DD/YY <input type="checkbox"/> Muscle aches MM/DD/YY <input type="checkbox"/> Shortness of breath MM/DD/YY <input type="checkbox"/> Vomiting MM/DD/YY <input type="checkbox"/> Abdominal pain MM/DD/YY <input type="checkbox"/> Diarrhea MM/DD/YY <input type="checkbox"/> Other _____ MM/DD/YY		
14. Underlying health conditions (Check all that apply): <input type="checkbox"/> Immunocompromised (specify): _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Chronic heart disease <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Other _____		
Risk Factors:		
15. Travel to or from a country in or near the Arabian Peninsula[†] within 14 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, which countries? _____ Dates: MM/DD/YY MM/DD/YY _____ Dates: MM/DD/YY MM/DD/YY		
16. Residence in country in or near the Arabian Peninsula[†] within 14 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, which country? _____		
17. Is the patient (Check all that apply): <input type="checkbox"/> Health care worker (HCW) <input type="checkbox"/> US military <input type="checkbox"/> Flight crew <input type="checkbox"/> Other _____		
18. A history of health care employment in or near the Arabian Peninsula[†] within 14 days of symptom onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, which countries? _____ Dates: MM/DD/YY MM/DD/YY		
19. A history of hospital admission in or near the Arabian Peninsula[†] within 14 days of symptom onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, which countries? _____ Dates: MM/DD/YY MM/DD/YY		

20. Had close contact¹ with a symptomatic person who had fever AND acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula†?
☐ Yes ☐ No ☐ Unk If yes, which countries? _____ Dates: MM/DD/YY | MM/DD/YY

21. Is a member of a cluster of patients with severe acute illness (e.g. fever and pneumonia requiring hospitalization) of unknown etiology in which MERS-CoV is being evaluated, in consultation with state and local health departments or CDC?
☐ Yes ☐ No ☐ Unk

22. Is a close contact of a person with a confirmed or probable case of MERS-CoV?
☐ Yes ☐ No ☐ Unk

23. Camel, bat or other animal contact in or near the Arabian Peninsula† within 14 days of symptom onset?
☐ Yes ☐ No ☐ Unk If yes, which countries? _____ Dates: MM/DD/YY | MM/DD/YY
 Type of contact _____

24. Consumption of camel milk products in or near the Arabian Peninsula† within 14 days of symptom onset?
☐ Yes ☐ No ☐ Unk If yes, which countries? _____ Dates: MM/DD/YY | MM/DD/YY
 Type of product _____

25. Consumption of uncooked date (fruit) products in or near the Arabian Peninsula† within 14 days of symptom onset?
☐ Yes ☐ No ☐ Unk If yes, which countries? _____ Dates: MM/DD/YY | MM/DD/YY
 Type of product _____

Clinical Outcomes

26. Does the patient have a non-MERS etiology for their respiratory illness but has not responded to appropriate therapy? ☐ Yes ☐ No ☐ Unk
 If yes, please specify: _____

27. Has the patient died? ☐ Yes ☐ No ☐ Unk
 Date of death? MM/DD/YY

Infection Control

28. When hospitalized, is/was the patient in a:
 a. Negative pressure room? ☐ Yes ☐ No ☐ Unk
 b. Private room? ☐ Yes ☐ No ☐ Unk

27. Are/Were surgical masks being used by the patient during transport?
☐ Yes ☐ No ☐ Unk

29. Are personal protective equipment being used by all HCW² and visitors when entering the patient's room (Check all that apply):
☐ Gloves ☐ Gowns ☐ Eye protection (goggles or face shield) ☐ N95/other form of respiratory protection (e.g., PAPR)
☐ Facemask ☐ Unk

Laboratory Testing **Merlin Case number:** _____

Tests Performed	Results				Tests Performed	Results			
	+	-	Pending (Pe)	Not done		+	-	Pending (Pe)	Not done
Influenza <input type="checkbox"/> A <input type="checkbox"/> B Test type: rapid <input type="checkbox"/> Y <input type="checkbox"/> N Test type: PCR <input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/>	<input type="checkbox"/>	<i>Streptococcus pneumoniae</i>			<input type="checkbox"/>	<input type="checkbox"/>
RSV			<input type="checkbox"/>	<input type="checkbox"/>	<i>Legionella pneumophila</i>			<input type="checkbox"/>	<input type="checkbox"/>
Human metapneumovirus			<input type="checkbox"/>	<input type="checkbox"/>	Blood culture			<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza 1-4			<input type="checkbox"/>	<input type="checkbox"/>	If positive _____			<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus			<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			<input type="checkbox"/>	<input type="checkbox"/>

MERS Testing- do not wait for Bureau of Public Health Laboratories (BPHL) test results to complete and upload this form to Merlin

Specimen	ID #	Date collected	State			Sent to BPHL?	Specimen	ID #	Date collected	State			Sent to BPHL?
			+	-	Pe					+	-	Pe	
Sputum		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	PF ³		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>
BAL		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	Stool		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>
TA ⁴		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>	Serum*		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>
⁵ NP ⁶ /OP ⁷		MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>			MM/DD/YY			<input type="checkbox"/>	<input type="checkbox"/>

*Use RED top or TIGER top tube

¹ Close contact is defined as a) any person who provided care for the patient, including a health care worker or family member, or had similarly close physical contact; or b) any person who stayed at the same place (e.g. lived with, visited) as the patient while the patient was ill.

² HCW: Health care workers

³ PF: Pleural fluid ⁴ BAL: Bronchial alveolar lavage ⁵ TA: Tracheal aspirate ⁶ NP: Nasopharyngeal ⁷ OP: Oropharyngeal

†Countries considered in the Arabian Peninsula and neighboring include: Bahrain, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian territories, Qatar, Saudi Arabia, Syria, the United Arab Emirates (UAE), and Yemen.